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URBAN DISTRICT OF LOOE

THE
ANNUAL REPORT
OF THE
MEDICAL OFFICER OF HEALTH
FOR THE YEAR

1953



P.J.FOX,

M.B., B.Ch., B.A.O., D.P.H.

URBAN DISTRICT OF LOOE

ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH FOR THE YEAR 1953

Mr. Chairman, Ladies and Gentlemen,

Once again the time has come round to present my Annual Report, and through it to convey a picture, in a very general way, of the health of the community in that part of Cornwall which goes to make up Health Area No 7. during the year 1953. I am again following the practise of providing a general preface which will be common to all six County District Annual Reports. In it I shall endeavour to set down my impressions as I tend to see them for the greater part of my time - as an Area Medical Officer of Health to some 53,000 people in this part of the County. Where matters peculiar to any one County District arise, comment on them will appear in the body of the Annual Report of that particular district.

My main impression of public health in 1953 is one of little change. There were no marked improvements or advances, but small gains were recorded in some directions. Thus the corrected birth rate for the Area was fractionally above the national figure at 15.6 per 1000 of population. The corrected death rate of 10.7 per 1000 of population in the Area compares favourably with the national figure of 11.4 per 1000. Although only one maternal death occurred it was sufficient to produce a rate of 1.36 per 1000 total births as against the national rate of 0.76 per 1000 total births. The stillbirth and infant mortality rate were both lower than the corresponding rates for England and Wales. Something of a set-back was experienced in tuberculosis where the total of cases notified was the highest for at least five years, and was in fact some 30% above the average total for the previous five years 1948-52. I shall deal with this matter in greater detail later in this preface. The estimated mid-1953 population of the Area at 53,276 showed a small decrease as compared with the figures of 53,520 for 1952. Of the individual County Districts which go to make up the Health Area, St. Germans R.D., Liskeard R.D., Saltash M.B. and Torpoint U.D. showed small reductions in population whilst Liskeard M.B. and Looe U.D. showed small increases. In no case were the figures sufficiently great to be of any significance or call for any comment. The birth rate was below the national figure of 15.5 per 1000, in St. Germans R.D., Torpoint U.D., Liskeard M.B., and Looe U.D., and above it in Liskeard R.D. and Saltash M.B. The death rate was below the national rate of 11.4 per 1000 in all County Districts with the exception of Liskeard M.B. where it was 18.6 per 1000. Looking no further than this one might conclude that the Borough of Liskeard was not a particularly healthy locality. On closer examination the real reason for this high death rate soon becomes apparent, and is seen to be directly due to the presence in the town of a hospital for aged and chronic sick persons, Lamellion Hospital. Prior to 1953 the deaths of patients in Lamellion Hospital were attributed to the district in which they previously resided. Towards the end of 1952 the Registrar-General decided that in future all persons dying in Lamellion Hospital would be regarded as having their place of residence there, and in consequence their deaths would be for statistical purposes attributed to the Borough of Liskeard. Whilst it might be reasonable to attribute the deaths of those who had spent many months or years prior to death in Lamellion Hospital or in the adjacent Part III accommodation in the Institution, it appears to me to be quite wrong to do so in those cases where the death had occurred within a short time of the person having been admitted from some district outside Liskeard Borough. It appears to me that some definite period of time should be set, inside which the person dying would be regarded as a temporary resident whose death would be transferred to the previous permanent place of residence. Such a dividing line might be set at six months, nine months or one year and it would avoid the present anomalous situation whereby the Borough of Liskeard is made statistically responsible for the death of a resident of some adjacent district who has been brought into Lamellion Hospital to breathe his last.

If the public are to appreciate and trust the statistics which appear in official reports they must have some assurance that they are based on a sound and reasonable interpretation of facts. As the practise in the matter under discussion does not seem to me to measure up to these criteria, I have taken it up with the General Register Office in the hope that a better and more exact method can be arrived at.

As in previous years heart disease is the most frequent single cause of death in the Area, with cancer again in second place. Of the various well defined heart diseases the most numerous was coronary disease where the small blood vessels supplying the heart itself become narrowed or blocked. Recent research into the association between occupation and this disease points to the fact that it appears to occur more commonly in those whose occupation is mainly sedentary. Thus in one interesting series it was found to be more common amongst drivers of London buses than amongst their colleagues who worked as conductors. Other recent work points to heavy consumption of tobacco as a possible aggravating factor in this disease. The cause or causes of Cancer still remain obscure. Whilst cancer of the stomach remains the most frequent type of fatal cancer in this Area there has been a noticeable increase in deaths from cancer of the bronchus and lung from 5 in 1952 to 14 deaths in 1953. As most of you are aware, there is a very strong presumption that heavy consumption of tobacco, particularly in the form of cigarettes, over a long period is a cause of bronchial and lung cancer. This belief has very recently been strengthened by the preliminary results of an enquiry and investigation which has been taking place into the smoking habits of members of the medical profession in this country. Without wishing to appear an alarmist on this subject, I think it is only reasonable to again remind all who use tobacco, and especially those adolescents, and young adults who will use it over a long span of years, that its consumption in large amount may be fraught with the danger of producing cancer of the bronchus or the lung, and to counsel moderation at least if abstinence cannot be achieved. One hopes that all the prominence recently given to this subject will stimulate further enquiry and research into it more especially as the powerful tobacco industry both here and in the United States has contributed a large sum of money to finance research. It is possible that such research will free tobacco of the suspicion that it can cause fatal disease, or it may suggest methods of removing the offending constituent, without destroying its widespread appeal.

Much has been written in recent years about the possibility, and even more the probability that tuberculosis will be eradicated in the foreseeable future. Tuberculosis has been and still is for the majority of its victims a chronic, disabling disease whose course is measured in months and years. Not so very long ago its outcome was frequently fatal, but in the period since the end of the last war notable advances in the treatment of tuberculosis have reduced the mortality. Thus in Cornwall the death rate for tuberculosis in 1952 was about half that of the year 1946, and the same is true if the figures for England and Wales are examined. This appreciable and very welcome reduction in mortality has infused into the outlook on tuberculosis a feeling of optimism that the turning in the long and tragic lane of tuberculosis disease has been reached, and that the end for which so many generations have striven is in sight. There has been a tendency in some quarters to draw from the improvement in mortality a conclusion that the situation in tuberculosis is showing a general all round improvement. Unfortunately this is not so since the incidence of the disease, as measured by new cases notified, shows no reduction. This is true of local figures for this Health Area, and for the larger numbers involved in the County, and the country as a whole. During the five year period 1948-52 the average number of new cases of tuberculosis notified in No. 7 Health Area each year was 51, and in none of these years did the total differ appreciably from the totals for other years or from the average for the five years.

It is therefore true to say that whereas mortality has been falling, the number of people contracting the disease showed no reduction over the period 1948-52. It is therefore not surprising to find that in 1953 there was no reduction in the incidence of tuberculosis in this Area. On the contrary there was a moderate increase, the total of 63 new cases representing a 24% increase over the average for the previous five years, and being 19 above the previous highest total of 54 cases in 1952. It would obviously not be reasonable or wise to take an unduly pessimistic view of these figures which are for one year only. It may well be that in 1954 the situation will improve and figures will return to a more normal level. Nevertheless it appears that there is at present no justification for much of the optimism which the reduced mortality rate has engendered. Tuberculosis is still prevalent to the extent that every year out of every thousand people in this Area one or two contract the disease and are thereby disabled for a long period, and become potential sources of infection to others.

At this point it is appropriate that the possible causes for the increased incidence of tuberculosis be examined, and here we leave the certainty of facts and figures, and enter the realms where conjecture plays a large part in providing the answer to our questions. I think it is reasonable to suppose that no single cause is responsible for the increase, and to state further that the broad general reasons for the increase are twofold. In the first place there probably has been some real increase in the amount of tuberculosis infection in the community, but it is unlikely that this accounts for all the increase in the incidence of the disease. In the second place better and more efficient methods of recognising the disease have been responsible for the bringing to light of cases which were previously overlooked. Some two years ago the Chest Clinic services in East Cornwall were reorganised and based on Plymouth instead of West Cornwall. When this reorganisation took place Dr. J.C. Mellor was appointed as Chest Physician to a Clinical Area which included East Cornwall. About the same time the Cornwall County Council appointed a full-time Tuberculosis Health Visitor, Miss S.L. Luxton. By their enthusiasm and hard work Dr. Mellor and Miss Luxton have provided an excellent service for handling cases of tuberculosis and their contacts and considerable assistance and advice has been given to the family doctor in this important matter. I believe that as a result of this, the family doctor has not hesitated to refer doubtful or chronic cases of chest ailments to the Chest Clinic and in that way some new cases of pulmonary tuberculosis have been discovered. Whilst the immediate impact of such discoveries tends to depress our hopes of eliminating this disease, the long-term outlook is improved by the discovery and recognition of such cases. Our main hope of controlling and eliminating tuberculosis lies in the early recognition and control of the affected individual and the careful checking and surveillance of the close contacts at least. Ideally all known regular contacts of any new case of tuberculosis should be examined and checked in an endeavour to find a possible source of infection and to discover any other individuals who had been infected either by our newly discovered case or by the original infecting source. Unfortunately this procedure is so difficult to put into effect as to be almost impossible, and at present our control and surveillance of contacts is confined to close family associates of the case, usually those living in the same house. We do recognise, and this is especially true of tuberculosis in young, and previously active adolescents and adults, that there may be a wide circle of contacts beyond the family which is not checked or investigated. The main reason for not checking contacts in this wider circle is one of manpower, since to carry it out thoroughly and conscientiously would require a large staff of health visitors and Chest Clinics would necessarily be involved in attending to the large number of contacts. An additional reason is the undesirability of disseminating widely the fact that any individual is suffering from tuberculosis. In the circumstances contact tracing is confined to the relatively restricted circle of relatives with whom the patient has been in close contact, and in which the chances of discovering the source of infection, and/or secondary cases of the disease would seem to be greatest.

Nevertheless this does allow some sources of infection and/or secondary cases (themselves further potential sources of infection) to escape recognition, and thereby to act as reservoirs, and disseminators of infection. For this reason we must accept the probability that eradication of tuberculosis will be a slow and sometimes a discouraging business. On the other hand new methods of prevention and treatment of this disease, together with a more enlightened and intelligent outlook on the part of the general public, will as time goes by exert an increasingly favourable influence on the situation.

Whilst on the subject of specific preventive measures against tuberculosis I can report two encouraging developments. Early in 1954 all children in the school-leaving group i.e. all those who attain the age of 14 years during 1954, will be examined by mass-radiography, and if after this, and one further simple skin test, they are found suitable, they will be offered (subject to parental consent) B.C.G. Vaccination against tuberculosis. This group has been selected because it is felt that adolescents when they leave school and commence work are exposed to a greater risk of tuberculosis infection, without in many cases the opportunity to develop the adults power of resistance to the disease. Vaccination with B.C.G. enables them to safely and quickly acquire a reasonable degree of resistance to tuberculosis, and thereby reduces the tragic toll which this disease has always exacted amongst adolescents, and young adults. In considering B.C.G. Vaccination we ought in fairness to this measure of prevention, try to understand the type of protection it affords, and the limitations which attach to it. Whilst it gives a good measure of protection against the amount of tuberculosis infection encountered in normal everyday life, it does guarantee protection against the less common occasions on which heavy infection is met with. As a corollary to this it can be said that B.C.G. Vaccination should not be called upon to protect the individual from the consequences of a careless and irresponsible mode of living, which in adolescents, and young adults is best described as "burning the candle at both ends". Properly regarded as a help in the prevention of tuberculosis, I feel sure that B.C.G. Vaccination represents a valuable new weapon in our fight against this disease.

I have written at some length about tuberculosis because in my view it represents one of the very few serious communicable diseases which remain as a challenge to public health and modern preventive medicine. In concluding this part of my report I should like to urge the need for taking, and holding a calm and balanced view on tuberculosis - neither being carried away by over-optimism, nor allowing gloom and pessimism to darken the picture. I believe that we can and will eradicate this wretched disease from our midst, but I feel sure the process will not be either rapid or easy.

Turning now to communicable diseases other than tuberculosis, the principal impression is that of epidemic measles in the first half of the year. In all 1565 cases were notified and this epidemic affected all districts in the Area with the exception of Torpoint Urban District. Pneumonia, whooping cough, and scarlet fever were all more prevalent than in 1952. There were three cases of diphtheria, of which two were in adults who had never been immunised. Two cases only of non-paralytic poliomyelitis were notified during 1953. In spite of the large influx of Visitors into Cornwall during the summer holiday season three cases only of food poisoning were notified in this Area during the year.

During recent years outbreaks of food poisoning in various parts of the country have brought home to the general public and especially to those who participate in or are associated with communal feeding in canteens and restaurants of one sort or another, the need for high standards of hygiene in the handling of food. This public interest has now progressed to the stage where, after fairly thorough investigations of the position, the Government has announced its intention to introduce new legislation which should ensure higher standards of hygiene in establishments where food is handled, and prepared for human consumption.

At present legislation in this important sphere is ill-defined and generally unsatisfactory. Under the new legislation the most important provision will be that which will require the registration of all premises dealing with food for human consumption. This will give District Councils the right to satisfy themselves that premises and particularly catering establishments, are of adequate size, and are reasonably equipped to handle food in a hygienic manner. At present it is difficult to insist on such reasonable standards and I have seen small catering establishments in which the amount of space devoted to the storage, preparation and cooking of food, and the cleansing, and storage of cooking utensils, and crockery, made it difficult if not impossible to maintain a reasonable standard of hygiene. Establishments of this type are in the minority, the majority of premises in which food is handled being reasonable in size and equipment. Owing however to the great influx of visitors into the County during the summer season, there is a distinct tendency for small, badly equipped establishments of this unsatisfactory type to spring hastily into existence at the beginning of the season with the intention of functioning for the summer season only. In such circumstances the proprietors are understandably not inclined or anxious to spend much on premises, and equipment, although in the course of four or five months a surprisingly large amount of food may be prepared and eaten in these places. Another difficulty which faces the catering industry springs from the seasonal fluctuation in trade. I refer to the necessity for engaging additional staff to meet the heavy summer demand on catering facilities, and here the difficulty of obtaining good, experienced employees for seasonal work is evident. This is unavoidable, but none the less unfortunate, since the commonest source of food poisoning is the inexperienced or careless food handler. Premises, and equipment may be above reproach, but if the food handlers are inexperienced or careless the danger of an outbreak of food poisoning is always present. Apart from the obvious necessity of sparing the public the distressing and exhausting illness which results from contaminated food, the occurrence of outbreaks of food poisoning in a tourist and holiday area, such as Cornwall is, can have serious financial repercussions on the tourist industry. It is only fair to add that in the last five years the number of cases of food poisoning in this Area has been extremely small, and in no case has any catering establishment been involved - a tribute to the good standards of cleanliness which exist in the catering industry. I trust these standards will be maintained in future years.

The welfare of old persons continued to give some anxiety during 1953. In several cases old men and women were reported as living alone in squalid insanitary circumstances, with, in addition, an appreciable risk of fire existed as a result of careless handling of oil lamps, candles, and paraffin oil. In almost all cases it was difficult or impossible to get relatives to undertake the care of or responsibility for these old persons. For much the same reasons which precluded relatives from helping - the senile, eccentric, and unreasonable attitude of most of these old people - it was not possible to find a home help who would face up to the task of cleaning up the home, and trying to get the old person to co-operate in keeping it reasonably clean. In the majority of cases, where it was felt that the old person could not continue to live at home, it was possible to persuade them to enter an institution or a hospital. In one case however an old man of 85 refused to see reason, and because of the filthy and insanitary conditions under which he was living application was made to a Court of Summary Jurisdiction under Section 47 of the National Assistance Act, 1948. The magistrates made an order for his removal and detention in Lamellion Hospital, Liskeard, where he subsequently remained of his own free will, without the necessity for having the order renewed.

I have written before of the importance of good housing in promoting and maintaining health and it is heartening to be able to report good progress on this front during 1953. In the rural districts it would appear that the numbers of new housing becoming available for letting are adequate to satisfy almost all the demands in those districts. In the urban parts of the Area the demand still exceeds the supply, but even here the clamour for rehousing is not so loud or insistent as in previous years.

It is true of course that the higher rents and rates attaching to most Council houses deter many families who need rehousing from applying, and in that respect, the most easily available criterion of the need for rehousing - the list of applicants - is not completely reliable. Up to now the necessity for providing new houses to make up for the acute shortage caused by the war has been paramount and in this Area practically nothing has been done to clear districts where most of the dwellings are old and in such a state of dilapidation and disrepair that they cannot be reconditioned. Whilst such slum districts are neither numerous nor large in extent they do exist in the urban parts of this Area, and now that the demand for new houses has eased consideration will have to be given to clearing these blocks of property, and rehousing the inhabitants, and it seems likely that in the near future the Government will press District Councils to produce schemes to deal with slum clearance.

During 1953 no scheme of major importance for water supply or sewage disposal was actually in hand although much work on planning and preliminary investigation of such schemes was undertaken in Liskeard, and St. Germans Rural Districts. In the former district further work on the comprehensive scheme to supply water throughout the Rural District from the river Fowey was more or less at a standstill pending the formation of a Joint Water Board. Although the need for proper systems of water supply, and sewage disposal is generally recognised, the very high cost of such schemes is one of the most difficult obstacles to their immediate and widespread implementation and here as in many other fields, projects have had to be graded in an agreed order of priority.

In this preface I have tried to put forward in as broad a manner as possible those aspects of public health practise and administration which have seemed to me important during the year 1953. The views and opinions expressed are not original, though they are necessarily coloured, or perhaps distorted, by my personal outlook. I have as far as possible tried to avoid dealing in matters of a controversial nature since I am conscious of my inability to take a truly impartial and unbiased view on such matters. I cannot conclude without expressing my thanks to members, and officers of the six County District Councils I serve, for the kindness, understanding, and co-operation they have extended to me during the past year.

I have the honour to be,

Your obedient Servant

P.J. FOX

Medical Officer of Health.

LOOE URBAN DISTRICT

Area of Urban District	1649.5 acres
Population (Registrar Generals Estimate)	3591
Number of Inhabited Houses	1293
Rateable Value	£40,779
Sum Represented by Penny Rate	£165

Vital Statistics for 1953

	<u>Male</u>	<u>Female</u>	<u>Total</u>
Live Births	29	17	46
	<u>Looe U.D.</u>	<u>Health Area 7</u>	<u>England & Wales</u>
Birth rate per 1000 of population	13.7	15.6	15.5.
	<u>Male</u>	<u>Female</u>	<u>Total</u>
Stillbirths	2	-	2
	<u>Looe U.D.</u>	<u>Health Area 7</u>	<u>England & Wales</u>
Stillbirth rate per 1000 of population	0.56	0.26	0.35
	<u>Male</u>	<u>Female</u>	<u>Total</u>
Deaths	20	24	44
	<u>Looe U.D.</u>	<u>Health Area 7</u>	<u>England & Wales</u>
Death rate per 1000 of population	9.1	10.7	11.4

Deaths Attributed to Pregnancy, Childbirth and the Puerperal State

NIL

Deaths of Infants Under One Year of Age

	<u>Male</u>	<u>Female</u>	<u>Total</u>
All causes	-	1	1
	<u>Looe U.D.</u>	<u>Health Area 7</u>	<u>England & Wales</u>
Infant Mortality rate per 1000 live births	21.7	26.4	26.8

Principal Causes of Deaths at All Ages

Heart Disease	17
Cancer(all sites)	14
Vascular lesions of the nervous system ("stroke")	3
Respiratory disease	3
Circulatory disease	2
Genito-urinary disease	1
Accident	1

Average Age of Death.

<u>Males</u>	<u>Females</u>
68	70

There is no feature of the foregoing statistics that calls for special comment. The Birth rate is below that of the surrounding area, and the country as a whole. The death rate is lower than that of the Health Area, and England and Wales. For the sixth year in succession no maternal deaths were registered, and the infant mortality rate stands at the low figure of 21.7 per 1000 live births.

INFECTIOUS DISEASE. Mainly as the result of an outbreak of measles in March and April, the total of infectious disease notified during the year rose to 99 cases, as compared with the figure of 16 in 1952. Measles cases accounted for 81 notifications the next most prevalent notifiable disease being pneumonia. One case of non-paralytic poliomyelitis in a young adult was notified. No deaths due to infectious disease were recorded during 1953.

The following are details of actual cases and case rates of infectious disease during the year under review:-

<u>Rate per 1000 of population</u>				
<u>Disease</u>	<u>Cases</u>	<u>Loos U.D.</u>	<u>Health Area No 7</u>	<u>England & Wales</u>
Measles	81	22.56	29.74	12.36
Pneumonia	12	3.34	1.41	0.84
Whooping Cough	4	1.11	3.55	3.58
Non-paralytic Poliomyelitis	1	0.28	0.04	0.04
<u>Rate per 1000 total (Live & still) births</u>				
Puerperal pyrexia	1	20.84	5.44	18.23

TUBERCULOSIS

During 1953 four new cases of tuberculosis were notified in the Urban District. All four were respiratory tuberculosis, and all four affected were females. The main incidence of the disease was in the 15-45 year age group in which three of the cases occurred. There were no deaths from tuberculosis during the year. At the end of 1953 there were 18 cases of respiratory tuberculosis, and 3 cases of non-respiratory tuberculosis known to be resident in the Urban District.

The following are details of new cases and case rates for the year 1953:-

<u>Age Group</u>	<u>New Cases</u>		<u>Deaths</u>	
	<u>M.</u>	<u>F.</u>	<u>M.</u>	<u>F.</u>
1	-	-		
1-5	-	-		
5-15	-	1	No deaths	
15-45	-	3		
45-65	-	-	Registered	
65 and over	-	-		
<u>Rate per 1000 of population</u>				
	<u>Loos U.D.</u>		<u>Health Area No 7</u>	<u>England & Wales</u>
New cases	1.11		1.18	Not stated
All cases	5.85		6.29	Not stated
Deaths	-		0.15	0.20

During the year 9 contacts of cases of tuberculosis were found to possess no demonstrable resistance to the disease and were given B.C.G. vaccine in an endeavour to reduce their liability to contract tuberculosis. Of these 9 susceptible contacts, 8 were below 15 years old.

NATIONAL ASSISTANCE ACT, 1948

No action under Section 47 of this Act was called for during 1953.

WATER SUPPLY.

An adequate supply of pure, treated water from the South East Cornwall Water Board was available in the Urban District throughout the year.

SEWERAGE AND SEWAGE DISPOSAL.

The bulk of the sewage from East and West Looe is discharged untreated into the tidal reaches of the Looe river, and although this cannot be regarded as satisfactory the nuisance caused is small in extent, and has not provoked complaints. From an engineering point of view the provision of satisfactory modern sewerage, and sewage disposal in Looe is a complicated problem, and in consequence the cost would be extremely high.

FOOD

In spite of the very large influx of summer visitors with the resulting expansion in catering and other food handling services, no complaint directed against these services was received, and no disease connected with unclean or unsound food came to notice during the year. I wrote last year of the importance of a well conducted catering industry in Looe, if the reputation of the town as a holiday resort is to be maintained, and I also expressed my anxiety at the inability of the Sanitary Inspector, Mr. Hicks, to give really adequate supervision to this matter during the holiday season. I must make it abundantly clear that the Sanitary Inspector's difficulty springs not from lack of diligence or ability, but from the very heavy pressure of other work particularly that connected with his appointment as Surveyor. I have put these views to the Council through the Health and Highways Committee, and although they recognise that the present state of affairs is unsatisfactory, they do not feel able to assume the additional financial burden which the appointment of an additional qualified official would place upon the rates.

Details of various inspections, and other activities connected with food are contained in the report of the Sanitary Inspector.

HOUSING

During 1953 a further 14 houses were completed and occupied on the Sunrising Estate. There are now 109 houses occupied on this estate, and a further 8 are under construction. In addition 16 houses built under private enterprise were completed. There is still a considerable demand for Council houses in Looe, although I think that there is at long last some slackening of the heavy, and insistent demand of recent years.

FACTORIES ACT, 1937

No difficulties were experienced in the operation of this Act in the Urban District during 1953.

REPORT OF SANITARY INSPECTOR

This report by Mr. J.C. Hicks, C.R.S.I., Sanitary Inspector and Surveyor follows. In spite of the multiplicity of duties undertaken by Mr. Hicks I have at all times found him most helpful, and co-operative, and I have to thank him for all the assistance he has given me during the past year.

REPORT OF THE SANITARY INSPECTOR

Factories Workshops and Bakehouses.

These were periodically inspected.

1. Inspections for purposes of provision as to health (Including inspections made by Sanitary Inspectors) Factories Act, 1937.

	<u>No on</u> <u>Register</u>	<u>Inspections</u>
(i) Factories in which sections 1,2,3,4, and 6 are to be enforced by Local Authorities	10	37
(ii) Factories not included in (i) in which section 7 applies	-	-
(iii) Others	3	6
	<u>13</u>	<u>43</u>

2. Cases in which defects were found

<u>Particulars</u>	<u>Defects Found</u>	<u>Defects Remedied</u>	<u>Referred to H.M. Inspector</u>
Want of Cleanliness (S 1)	1	1	-
Ineffective drainage floors	-	-	-
Sanitary Conveniences	-	-	-
Other	-	-	-
	<u>1</u>	<u>1</u>	<u>-</u>

Water

During the year the water supply continued to be satisfactory in quality and quantity.

A periodical check was made in August and the sample proved to be highly satisfactory (Class 1).

140 lineal yards of 3 inch cast iron watermain together with valve, hydrant, and washout valve was laid to the East Cliff Estate.

Refuse Collection

The system operating in 1952 was continued, i.e. Refuse is collected once weekly during the winter months, and twice weekly during the summer months. Refuse is collected from 1534 premises.

Inspection of Dwelling Houses

Total number of dwelling houses inspected for defects etc.	98
Other, i.e. drainage	<u>29</u> <u>127</u>

Clean Food Campaign

Number of Food Premises in Area:-

Hotels	24	
Guest Houses	<u>18</u>	42
Cafes	<u>13</u>	13
<u>Shops</u>	<u>43</u>	43
		<u>98</u>

Inspections of above Premises:-

Hotels & Cafes	25
Other	<u>31</u>
	<u>56</u>

From inspections carried out at the thirteen Cafes, it was found that seven had good kitchens with modern equipment. Of the remaining six it would appear that the kitchen space is inadequate for the business carried out, and the Owners attention have been drawn to this fact. Up to the end of the year arrangements have been made for two of these kitchens to be extended and modernized. It is not possible to extend the kitchens in all cases, but better equipment is being installed wherever possible.

Educational Activity

In August, 1953, the following leaflets were supplied to all the above mentioned premises:-

"Food Safety First"

"The Customers Health is in Your Hands"

"Kitchen Hygiene"

During November a Circular letter was sent drawing the attention of the Proprietors to the Ministry Leaflet, "Clean Catering".

Section 14 Food and Drugs Act, 1938.

The following premises are registered under the above Act:-

3 Ice Cream Factories (Conforming to the Heat Treatment Regulations)

20 Premises for the Storage and Sale of Ice-Cream

8 Preserved Food (Butchers)

1 -do-(Canning Factory)

32

During 1953 seventy two samples of Ice Cream were taken for evidence of bacteria. contamination and for grading . Twelve of these samples were analysed for fat content, and were above the minimum standard laid down, varying between 5.8% and 12.9%

The results for grading were as follows:-

53 Samples Grade 1

14 Samples Grade 2

3 Samples Grade 3

0 Samples Grade 4

70

2 Samples did not reach the Laboratory

72

Food Canning

During the year the following pilchards etc. were dealt with at the Canning Factory.

Pilchards	- 14 oz Oval Cans	258,814
	7 oz Oval Cans	2,142,809
	No 1 Tall Cans	30,452

Mackerel	- No 1 Tall Cans	166,200
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Herring Roes	- 8oz Oval Cans	8,758
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The following were certified for export to Italy:-

62 half Casks Pilchards
676 quarter casks Pilchards

Milk and Dairies Regulations, 1949

There are nine dairies in the Urban District. It was noted that crates of milk were left at points along the highway for retailers to collect and were liable to contamination from animals. A letter was sent to all retailers requesting that if possible a depot should be provided to receive the milk, and if not practicable raised platforms should be provided. The retailers have complied with this request.

Condemned Food

During the year the following has been condemned as unfit for human consumption:-

120 tins Various Foods.
6 Tins Ham - Weight 67 lbs 6 ozs
125 lbs of Beef
28 lbs of Frozen Egg.
209 Slabs Herring Roes. Weight 252 stones.

All food condemned excepting the beef was destroyed at the Incinerator. The beef was returned to the depot for purposes other than human consumption.

J.C. HICKS

Surveyor and Sanitary Inspector
Looe Urban District Council.

APPENDIX 1

PRINCIPAL CAUSES OF DEATH - ALL AGES - 1953

DISEASE	St. GERMANS R.D.	LISKEARD R.D.	SALTASH M.B.	TORPOINT U.D.	LISKEARD M.B.	LOOE U.D.	HEALTH AREA NO. 7
Heart Disease	65	72	33	12	67	17	266
Cancer(all sites)	37	23	11	10	10	14	105
Vascular lesions of the nervous system ("Stroke")	10	19	19	6	15	3	72
Respiratory disease	19	11	5	4	4	3	46
Circulatory disease	9	3	5	3	3	2	25
Genito-urinary disease	3	5	5	-	2	1	16
Accidents	2	6	4	-	2	1	15
Digestive disease	4	4	3	2	-	-	13
Diabetes	4	1	3	-	1	-	9
Tuberculosis	2	2	3	-	1	-	8
Suicide	3	2	-	-	2	-	-

APPENDIX 2.

TYPES OF HEART DISEASE AND CANCER CAUSING DEATH - 1953

TYPE OF DISEASE	ST, GERMANS R.D.	LISKEARD R.D.	SALTASH M.B.	TORPOINT U.D.	LISKEARD M.B.	LOOE U.D.	HEALTH AREA NO 7
Coronary disease							
angina	28	23	10	3	7	4	75
Hypertension with heart disease	5	5	4	-	4	3	21
Other heasrt disease	32	44	19	9	56	10	170
Cancer of stomach	9	4	1	1	3	3	21
Cancer of bronchus and lung	9	3	-	1	-	1	14
Cancer of breast	2	-	-	-	1	2	5
Cancer of womb	2	1	2	-	-	1	6
Other cancers	15	15	8	8	6	7	59

APPENDIX 3

DEATHS BY AGE GROUPS - 1953

DISTRICT	0-5 years	5-15 years	15-45 years	45-65 years	65-75 years	75years & Upward	All Ages
ST.GERMANS R.D.	8	2	5	43	53	74	185
LISKEARD R.D.	8	-	6	35	42	78	169
SALTASH M.B.	6	-	7	23	26	46	108
TORPOINT U.D.	2	-	3	11	13	13	42
LISKEARD M.B.	-	-	2	18	26	72	118
LOOE U.D.	1	-	4	4	14	21	44
HEALTH AREA NO 7.25		2	27	134	174	304	666

APPENDIX 4

AVERAGE AGE AT DEATH - 1953

DISTRICT	MALES	FEMALES
ST. GERMANS R.D.	69	66
LISKEARD R.D.	65	72
SALTASH M.B.	65	65
TORPOINT U.D.	66	61
LISKEARD M.B.	74	78
LOOE U.D.	68	70
HEALTH AREA NO 7	68	69

APPENDIX 5

TUBERCULOSIS

INCIDENCE OF, AND MORTALITY FROM TUBERCULOSIS IN HEALTH AREA NO 7 - 1953

AGE GROUP	NEW CASES		DEATHS	
	M	F	M	F
0 - 1 YEAR	-	-	-	-
1 - 5 YEARS	3	1	1	-
5 - 15 YEARS	5	7	-	-
15 - 45 YEARS	15	15	1	1
45 - 65 YEARS	9	3	2	1
65 YEARS & UPWARD	5	-	2	-
TOTALS	37	26	6	2

	MALES	FEMALES
CASE RATE PER 1000 OF POPULATION (NEW CASES)	0.69	0.49
MORTALITY RATE PER 1000 OF POPULATION	0.11	0.04

CASE RATES AND MORTALITY RATES PER 1000 OF POPULATION BY COUNTY DISTRICTS IN HEALTH AREA NO 7 - 1953

DISTRICT	NEW CASES	TOTAL CASES AS AT 31.12.53	DEATHS
ST. GERMANS R.D.	1.44	6.31	0.12
LISKEARD R.D.	0.71	5.33	0.14
SALTASH M.B.	1.38	6.54	0.25
TORPOINT U.D.	1.34	6.26	-
LISKEARD M.B.	1.16	9.26	0.23
LOOE U.D.	1.11	5.85	-
HEALTH AREA NO 7	1.18	6.29	0.15

APPENDIX 6

B.C.G. VACCINATIONS AGAINST TUBERCULOSIS - 1953

DISTRICT	UNDER 1 YEAR	1-5 YEARS	5-10 YEARS	10-15 YEARS	15 YEARS AND OVER
ST. GERMANS R.D.	8	9	7	6	1
LISKEARD R.D.	2	2	2	1	-
SALTASH M.B.	4	2	1	1	2
TORPOINT U.D.	3	10	10	3	-
LISKEARD M.B.	2	3	1	1	11
LOOE U.D.	1	3	3	1	1
HEALTH AREA NO 7	20	29	24	13	15

